

1 XAVIER BECERRA
2 Attorney General of California
3 STEVEN D. MUNI
4 Supervising Deputy Attorney General
5 MEGAN R. O'CARROLL
6 Deputy Attorney General
7 State Bar No. 215479
1300 I. Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7543
Facsimile: (916) 327-2247
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO March 29 2019
BY CRN FERNANDEZ ANALYST

BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

Case No. 950-2016-000898

Anthony Martin Kelly, P.A.
466 Del Norte Ave.
Yuba City, Ca 95991

ACCUSATION

Physician's and Surgeon's Certificate
No. PA 13023,

Respondent.

Complainant alleges:

PARTIES

1. Maureen L. Forsyth (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Physician Assistant Board, Department of Consumer Affairs (Board).

2. On or about February 16, 1993, the Physician Assistant Board issued Physician's and Surgeon's Certificate Number PA 13023 to Anthony Martin Kelly, P.A. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2020, unless renewed.

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1 “(2) When the standard of care requires a change in the diagnosis, act, or omission that
2 constitutes the negligent act described in paragraph (1), including, but not limited to, a
3 reevaluation of the diagnosis or a change in treatment, and the licensee’s conduct departs from the
4 applicable standard of care, each departure constitutes a separate and distinct breach of the
5 standard of care.

6 “(d) Incompetence.

7 “(e) The commission of any act involving dishonesty or corruption which is substantially
8 related to the qualifications, functions, or duties of a physician and surgeon.

9 “(f) Any action or conduct which would have warranted the denial of a certificate.

10 “(g) The practice of medicine from this state into another state or country without meeting
11 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
12 apply to this subdivision. This subdivision shall become operative upon the implementation of the
13 proposed registration program described in Section 2052.5.

14 “(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and
15 participate in an interview by the board. This subdivision shall only apply to a certificate holder
16 who is the subject of an investigation by the board.”

17 8. Section 3502.1¹ of the Code states, in pertinent part:

18 “(a) In addition to the services authorized in the regulations adopted by the Medical Board
19 of California, and except as prohibited by Section 3502, while under the supervision of a licensed
20 physician and surgeon or physicians and surgeons authorized by law to supervise a physician
21 assistant, a physician assistant may administer or provide medication to a patient, or transmit
22 orally, or in writing on a patient’s record or in a drug order, an order to a person who may
23 lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

24 “(1) A supervising physician and surgeon who delegates authority to issue a drug order to a
25 physician assistant may limit this authority by specifying the manner in which the physician
26 assistant may issue delegated prescriptions.

27 ¹ Effective: January 1, 2016. The previous language of section 3502.1, as set forth
28 between January 1, 2013, and December 31, 2015, and as set forth between January 1, 2008, and
December 31, 2012, underwent stylistic changes but no substantive changes occurred.

1 “(2) Each supervising physician and surgeon who delegates the authority to issue a drug
2 order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific,
3 formulary and protocols that specify all criteria for the use of a particular drug or device, and any
4 contraindications for the selection. Protocols for Schedule II controlled substances shall address
5 the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is
6 being administered, provided or issued. The drugs listed in the protocols shall constitute the
7 formulary and shall include only drugs that are appropriate for use in the type of practice engaged
8 in by the supervising physician and surgeon. When issuing a drug order, the physician assistant
9 is acting on behalf of and as an agent for a supervising physician and surgeon.

10 “(b) “Drug order” for purposes of this section, means an order for medication which is
11 dispensed to or for a patient, issued and signed by a physician assistant acting as an individual
12 practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal
13 Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this
14 section shall be treated in the same manner as a prescription or order of the supervising physician,
15 (2) all references to ‘prescription’ in this code and the Health and Safety Code shall include drug
16 orders issued by physician assistants pursuant to authority granted by their supervising
17 physicians, and (3) the signature of a physician assistant on a drug order shall be deemed to be the
18 signature of a prescriber for purposes of this code and the Health and Safety Code.

19 “(c) A drug order for any patient cared for by the physician assistant that is issued by the
20 physician assistant shall either be based on the protocols described in subdivision (a) or shall be
21 approved by the supervising physician before it is filled or carried out.

22 “(1) A physician assistant shall not administer or provide a drug or issue a drug order for a
23 drug other than for a drug listed in the formulary without advance approval from a supervising
24 physician and surgeon for the particular patient. At the direction and under the supervision of a
25 physician and surgeon, a physician assistant may hand to a patient of the supervising physician
26 and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon,
27 manufacturer as defined in the Pharmacy Law, or a pharmacist.

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1 “(2) A physician assistant may not administer, provide or issue a drug order for Schedule II
2 through Schedule V controlled substances without advance approval by a supervising physician
3 and surgeon for the particular patient unless the physician assistant has completed an education
4 course that covers controlled substances and that meets standards, including pharmacological
5 content, approved by the board. The education course shall be provided either by an accredited
6 continuing education provider or by an approved physician assistant training program. If the
7 physician assistant will administer, provide, or issue a drug order for Schedule II controlled
8 substances, the course shall contain a minimum of three hours exclusively on Schedule II
9 controlled substances. Completion of the requirements set forth in this paragraph shall be verified
10 and documented in the manner established by the board prior to the physician assistant's use of a
11 registration number issued by the United States Drug Enforcement Administration to the
12 physician assistant to administer, provide, or issue a drug order to a patient for a controlled
13 substance without advance approval by a supervising physician and surgeon for that particular
14 patient.

15 “(3) Any drug order issued by a physician assistant shall be subject to a reasonable
16 quantitative limitation consistent with customary medical practice in the supervising physician
17 and surgeon's practice.

18 “(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a
19 patient's medical record in a health facility or medical practice, shall contain the printed name,
20 address, and phone number of the supervising physician and surgeon, the printed or stamped
21 name and license number of the physician assistant, and the signature of the physician assistant.
22 Further, a written drug order for a controlled substance, except a written drug order in a patient's
23 medical record in a health facility or a medical practice, shall include the federal controlled
24 substances registration number of the physician assistant and shall otherwise comply with the
25 provisions of Section 11162.1 of the Health and Safety Code. Except as otherwise required for
26 written drug orders for controlled substances under Section 11162.1 of the Health and Safety
27 Code, the requirements of this subdivision may be met through stamping or otherwise imprinting
28 on the supervising physician and surgeon's prescription blank to show the name, license number,

1 and if applicable, the federal controlled substances registration number of the physician assistant,
2 and shall be signed by the physician assistant. When using a drug order, the physician assistant is
3 acting on behalf of and as the agent of a supervising physician and surgeon.

4 “(e) The medical record of any patient cared for by a physician assistant for whom the
5 physician assistant’s Schedule II drug order has been issued or carried out shall be reviewed and
6 countersigned and dated by a supervising physician and surgeon within seven days.

7 “(f) All physician assistants who are authorized by their supervising physicians to issue
8 drug orders for controlled substances shall register with the United States Drug Enforcement
9 Administration (DEA).

10 “(g) The board shall consult with the Medical Board of California and report during its
11 sunset review required by Division 1.2 (commencing with Section 473) the impacts of exempting
12 Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to
13 review and countersign the affected medical record of a patient.”

14 9. Section 2261 of the Code states:

15 “Knowingly making or signing any certificate or other document directly or indirectly
16 related to the practice of medicine or podiatry which falsely represents the existence or
17 nonexistence of a state of facts, constitutes unprofessional conduct.”

18 10. Section 2266 of the Code states: “The failure of a physician and surgeon to maintain
19 adequate and accurate records relating to the provision of services to their patients constitutes
20 unprofessional conduct.”

21 11. California Code of Regulations, title 16, section 1399.521 states, in pertinent part:

22 “In addition to the grounds set forth in section 3527, subdivision (a) of the Code, the
23 committee may deny, issue subject to terms and conditions, suspend, revoke, or place on
24 probation a physician assistant for the following causes:

25 “(a) Any violation of the State Medical Practice Act which would constitute unprofessional
26 conduct for a physician and surgeon.”

27 “...”

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1 **COST RECOVERY**

2 12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
3 administrative law judge to direct a licentiate found to have committed a violation or violations of
4 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
5 enforcement of the case, with failure of the licentiate to comply subjecting the license to not being
6 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
7 included in a stipulated settlement.

8 **FIRST CAUSE FOR DISCIPLINE**

9 **(Gross Negligence)**

10 13. Respondent is subject to disciplinary action under sections 3527, 2234, subdivision
11 (b), 3502.1, and California Code of Regulations, title 16, section 1399.521, in that he was grossly
12 negligent in his prescribing of controlled medications to Patients 1, 2, 3, 4, and 5². The
13 circumstances are as follows:

14 14. **Patient 1.** Respondent has been treating Patient 1 since at least 2011. As of 2013,
15 Respondent was prescribing Patient 1 the following medications per month: 180 tablets of
16 hydrocodone with acetaminophen 10/650; Ambien 15 mg/day; Soma 3/day; Xanax 6 mg/day; and
17 Adderall 30 mg/day. Midway through 2013, Respondent added Bontril. During portions of
18 2014, 2015, and 2016, Respondent prescribed both Bontril and Adderall. The doses varied over
19 time. Respondent did not make any notes in Patient 1's medical records to explain the reason for
20 prescribing the Bontril or the Adderall. There is no explanation as to why the dose of Ambien
21 was so high, or why it was being prescribed in combination with other sedatives and stimulants.
22 On or about February 12, 2019, Respondent was interviewed by Board investigators. The
23 investigators asked Respondent why he was prescribing the Bontril and the Adderall to Patient 1.
24 He stated it was to lose weight and to treat ADD.

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28 ² The true identities of Patients 1 through 5 are concealed in this pleading to protect their
privacy. The patients' true identities will be provided with discovery

1 15. Patient 1's medical records do not contain any diagnosis of ADD for Patient 1, or any
2 response to treatment or reason for alteration of the Adderall dosage over the years she saw
3 Respondent. Similarly, the records do not contain any diagnosis explaining why Patient 1 was
4 prescribed Bontril, or what her response to treatment was for this medication. Respondent
5 prescribed Patient 1 a very high dose of Xanax of 6 mg/day between 2013 and 2017. There is no
6 detailed description in the medical records to explain why Patient 1 required this high dose or any
7 goal to decrease it between 2013 and 2017. Respondent merely states she has anxiety and on
8 several notes states that the anxiety is due to concerns over a possible foreclosure, or that the
9 anxiety is worse, but the description does not state why the high doses are necessary, or change
10 over long periods of time. In June of 2017, Respondent reduces the Xanax prescription by
11 approximately 50%, but the record does not state why this occurred, and the record continues to
12 list the incorrect, high dose of Xanax. Later in 2017, the medication is removed from the list of
13 medications, even though Respondent continued to prescribe it to her at a lower dose. By 2018,
14 Patient 1 was receiving 2 mg/day of Xanax. This is not listed on her medical record.

15 16. **Patient 2.** Respondent saw Patient 2 since at least 2013. Patient 2 is the husband of
16 Patient 1. Respondent prescribed the following medications to Patient 2: hydrocodone with
17 acetaminophen 10/650; Ambien 15 mg/day; Soma 3/day; Xanax 6 mg/day; and Adderall 30
18 mg/day. As with Patient 1, Respondent dramatically reduced the dose of Xanax in 2017, without
19 providing any reason in the medical records. The records before 2017 did not explain why the
20 high dose was needed. There is no explanation in the records as to why the dose of Ambien was
21 so high, or why it was being prescribed in combination with other sedatives and stimulants.
22 Respondent stopped and started Adderall in Patient 2 on various occasions without explaining the
23 medical rationale in the medical records.

24 17. Between February of 2013 and February of 2014, Respondent prescribed
25 hydrocodone with acetaminophen to Patient 2 in amounts that well exceeded 4,000 milligrams
26 per day of acetaminophen. For example, on February 11, 2013, March 12, 2013, April 10, 2013,
27 May 6, 2013, June 5, 2013, and July 3, 2013, Patient 2 filled prescriptions from Respondent of
28 200 tablets each for hydrocodone 10/acetaminophen 650. On September 9, 2013 and September

1 26, 2013, Patient 2 filled prescriptions from Respondent of 210 tablets each for hydrocodone
2 10/acetaminophen 650. On October 24, 2013, and December 16, 2013, Patient 2 filled
3 prescriptions from Respondent for 220 tablets each of hydrocodone 10/acetaminophen 650. And
4 on November 25, 2013, January 15, 2014, and February 15, 2014, Patient 2 filled prescriptions
5 from Respondent of 240 tablets each for hydrocodone 10/acetaminophen 650. Over this 12-
6 month period, there was no 30-day period during which Patient 1 was receiving less than 4,000
7 milligrams per day of acetaminophen, and on average over the 12-month period, Patient 1 was
8 receiving approximately 5,734 milligrams per day of acetaminophen.

9 18. During his interview with Board investigators on or about February 12, 2019,
10 Respondent acknowledged that Patient 2 was receiving in excess of the maximum recommended
11 acetaminophen dosage from him. Respondent could not recall his medical thought process for the
12 prescriptions, other than that Patient 2 had experienced an injury around this time, and he reported
13 that he received greater pain relief when taking the extra Tylenol.

14 19. **Patient 3.** Respondent prescribed numerous controlled medications to Patient 3
15 between 2013 and 2018. He prescribed her Norco, Soma, Adderall, Phentermine, and Nuvigil. In
16 2017, Respondent prescribed Patient 3 both Norco and a Butrans patch. Respondent increased
17 the Butrans the next month, but continued the Norco prescriptions for a time. There was no
18 explanation of this change in the records. Respondent did not document the medical rationale for
19 prescribing multiple stimulants in combination with sedating medication.

20 20. **Patient 4.** Patient 4 has been a long time patient of Respondent's. As of 2013,
21 Respondent was prescribing Patient 4 Norco, Fentanyl patch, and Xanax. On or about September
22 1, 2014, October 2, 2014, November 12, 2014, December 5, 2014, January 2, 2015, January 29,
23 2015, Patient 4 filled prescriptions from Respondent for 15 patches of Fentanyl, 75 mcg/hr.
24 Again between March and June of 2016, Respondent prescribed Patient 4 Fentanyl patches at a
25 rate of approximately 15 per month. Board investigators asked Respondent why he prescribed in
26 excess of 10 patches per month for this patient, and he responded that he believed it was because
27 she had an increase in pain levels. The medical records during these times do not reflect any
28 specific reasoning for changing from the standard maximum dose during these months.

1 21. **Patient 5.** Respondent took over writing prescriptions for Patient 5 in 2014 and
2 2015. He prescribed her Norco, Fentanyl patch, and Xanax. Previous providers had prescribed
3 approximately 10 Fentanyl patches 75 mcg/hr each month or 6-week period. Beginning in
4 approximately March of 2015, Respondent increased the Fentanyl patch to 15 patches per month.
5 He continued this pattern throughout all of 2015, and 2016. He continued the excess Fentanyl
6 patches throughout June of 2017, with the exception of one month in January of 2017 when he
7 only prescribed 10 patches. There is no indication in the medical records of the reason for the
8 increase or the decrease.

9 22. Board investigators asked Respondent why he prescribed in excess of 10 patches per
10 month for this patient, and he responded that he believed it was because she had an increase in
11 pain levels. The medical records during these times do not reflect any specific reasoning for
12 changing from the standard dose during these months. Board investigators asked Respondent if
13 the patient had issues with the patches adhering to her skin and Respondent explained that she did
14 not.

15 23. Respondent's prescribing to Patient 1, 2, 3, 4, and 5 was grossly negligent for his acts
16 and omissions, including but not limited to, the following:

- 17 a. Prescribing Patients 4 and 5 with 15 patches of Fentanyl per month without explanation
18 or justification for exceeding the maximum recommended amount of 10 patches per
19 month;
- 20 b. Prescribing Patients 1 and 2 medications including more than 4,000 mg of
21 acetaminophen per day;
- 22 c. Prescribing Patient 1, 2, and 3 high doses of benzodiazepines in combination with other
23 sedating and stimulant medications without documenting any medical justification or
24 plan for this unusual dose and combination of medications; and
- 25 d. Prescribing controlled medications to Patients 1, 2, 3, 4, and 5 without documenting a
26 corresponding diagnosis, long-term treatment plan or response to treatment or changes
27 in treatment.

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1 **SECOND CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts RNA)**

3 24. Respondent is subject to disciplinary action under sections 3527, 2234, subdivision
4 (c), 3502.1, and California Code of Regulations, title 16, section 1399.521, in that he was
5 repeatedly negligent in his prescribing of controlled medications to Patients 1, 2, 3, 4, and 5. The
6 circumstances are as follows:

7 25. Paragraphs 14 through 22, above, are incorporated by reference and alleged here as if
8 fully set forth.

9 26. Respondent's prescribing to Patient 1, 2, 3, 4, and 5 was repeatedly negligent for his
10 acts and omissions, including but not limited to, the following:

11 e. Prescribing Patients 4 and 5 with 15 patches of Fentanyl per month without explanation
12 or justification for exceeding the maximum recommended amount of 10 patches per
13 month;

14 f. Prescribing Patients 1 and 2 medications including more than 4,000 mg of
15 acetaminophen per day;

16 g. Prescribing Patient 1, 2, and 3 high doses of benzodiazepines in combination with other
17 sedating and stimulant medications without documenting any medical justification or
18 plan for this unusual dose and combination of medications; and

19 h. Prescribing controlled medications to Patients 1, 2, 3, 4, and 5 without documenting a
20 corresponding diagnosis, long-term treatment plan or response to treatment or changes
21 in treatment.

22 **THIRD CAUSE FOR DISCIPLINE**

23 **(Gross Negligence)**

24 27. Respondent is subject to disciplinary action under sections 3527, 2234, subdivision
25 (b), and California Code of Regulations, title 16, section 1399.521, in that he was grossly
26 negligent in providing injections to Patients 1, 2, 3, and 4. The circumstances are as follows:

27 28. Respondent's medical records for Patient 1 indicate that she received trigger point
28 injections from Respondent in his office on or about the following dates: August 2, 2013,

1 February 5, 2014, February 12, 2014, August 20, 2014, February 17, 2015, May 15, 2015, June
2 10, 2015, September 2, 2015, January 10, 2016, January 28, 2016, February 29, 2016, May 30,
3 2016, June 20, 2016, July 11, 2016, August 15, 2016, August 22, 2016, September 19, 2016,
4 October 15, 2016, and November 21, 2016. Respondent did not document the location and
5 substance injected in these treatments.

6 29. Respondent documented injecting Kenalog (a synthetic glucocorticoid corticosteroid
7 anti-inflammatory) into Patient 1's left hip on August 4, 2014, December 18, 2014, December 30,
8 2014, January 2, 2015, and June 23, 2015. Respondent documented injecting Kenalog into
9 Patient 1's left foot on November 10 and 15, 2014, May 26, 2015, July 30, 2015, and September
10 12, 2015. Respondent documented injecting Kenalog into Patient 1's right foot on March 9, and
11 31, 2015.

12 30. Respondent's medical records for Patient 2 indicate that he received trigger point
13 injections on or about December 31, 2012, and again on January 4, 2013, January 21, 2013,
14 March 6, 2013, March 23, 2013, June 4, 2013, June 27, 2013, and July 20, 2013. Respondent did
15 not document the location and substance injected in these treatments. Respondent documented
16 injecting Kenalog into Patient 2's knees on or about August 5, 2015, August 31, 2015, December
17 10, 2015, December 29, 2015, and January 26, 2016. Respondent continued to inject Kenalog into
18 Patient 2's joints frequently throughout 2016.

19 31. Respondent's medical records for Patient 3 indicate that she received trigger point
20 injections from Respondent in his office on or about the following dates: January 12, 2017,
21 March 7, 2017, March 23, 2017, April 6, 2017, April 28, 2017, April 29, 2017, May 10, 2017,
22 and May 18, 2107. Respondent did not document the location and substance injected in these
23 treatments.

24 32. Respondent injected Kenalog into Patient 3's right shoulder on or about January 26,
25 2017, February 14, 2017, February 23, 2017, March 23, 2017, and May 10, 2017. Respondent
26 injected Kenalog into Patient 3's right shoulder on or about February 14, and 23, 2017, and May
27 10, 2017. Respondent injected Kenalog into both Patient 3's shoulders on or about March 30,
28 2017.

33. In April of 2019, Respondent diagnosed Patient 3 with having a possible left wrist fracture. The History of present illness and review of symptoms for that day do not mention the wrist injury. The plan Respondent documented was to inject Kenalog into the wrist. There was no order for an x-ray noted in the record or follow up on a possible fracture. Patient 3 continued to receive Kenalog injections in the wrist on April 19, 2018, May 2, 2018, and May 17, 2018.

34. Respondent's medical records for Patient 4 indicate that she received trigger point injections from Respondent in his office on or about the following dates: February 6, 2016, August 30, 2016, October 31, 2016, December 5, 2016, January 26, 2017, February 27, 2017, and May 27, 2017. Patient 4's records continue to state that she received trigger point injections on multiple other dates throughout her treatment. Respondent did not document the location and substance injected in these treatments.

35. Respondent injected Kenalog into Patient 4's left foot on or about March 13, 2016, but did not state the amount or document a foot examination. He injected the left foot again ten days later, and again in April, as well as three times in July. He injected both feet in August of 2016, and in May and August of 2017.

36. Respondent's treatment with injections to Patient 1, 2, 3, and 4, was repeatedly negligent for his acts and omissions, including but not limited to, the following:

- a. Failing to document the type and amount of medication and location of site injected for Patient 1, 2, 3, and 4; and
- b. Providing excessive amounts of steroid injections into the same joints within a short timeframe for Patients, 1, 2, 3, and 4.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts RNA)

37. Respondent is subject to disciplinary action under sections 3527, 2234, subdivision (c), and California Code of Regulations, title 16, section 1399.521, in that he was repeatedly negligent in providing injections to Patients 1, 2, 3, and 4. The circumstances are as follows:

38. Paragraphs 28 through 35, above, are incorporated by reference and alleged here as if fully set forth.

1 39. Respondent's injections to Patients 1, 2, 3, and 4, were repeatedly negligent for his
2 acts and omissions, including but not limited to, the following:

- 3 a. Failing to document the type and amount of medication and location of site injected for
4 Patient 1, 2, 3, and 4; and
5 b. Providing excessive amounts of steroid injections into the same joints within a short
6 timeframe for Patients, 1, 2, 3, and 4.

7 **FIFTH CAUSE FOR DISCIPLINE**

8 **(Inadequate or Inaccurate Records)**

9 40. Respondent subject to disciplinary action under sections 2266 and 3527 in that he
10 failed to maintain adequate and accurate records related to the provision of medical services to
11 Patients 1, 2, 3, 4, and 5. The circumstances are as follows:

12 41. Paragraphs 13 through 39, above, are incorporated by reference and alleged here as if
13 fully set forth.

14 42. During his interview with Board investigators, Respondent acknowledged that he
15 made numerous errors in charting involving Patients 1, 2, 3, 4, and 5. He attributed many of the
16 errors to mistake and to inadvertently cutting and pasting previous notes, or failing to alter
17 automatically populating information from previous visits.

18 43. The medical records for the patients demonstrate examples of these incorrect
19 statements in virtually every note for all five patients. For example, Patient 1 has numerous
20 History and Physicals, examinations, and review of systems that are identical between visits and
21 that not correspond to the treatment plans. In December of 2013, Respondent diagnosed Patient 1
22 with bronchitis, although her vital signs are no different than previous visits. In April of 2014,
23 Respondent documented treating Patient 1 with a nebulizer and Zithromax. Three days later he
24 documented treating her with the same medications, but the lung examination states that her lungs
25 are both clear, and that they are positive for wheezes and rales. Again in December of 2015,
26 Respondent treated Patient 1 with Rocephin (a cephalosporin antibiotic) and Kenalog and a
27 nebulizer, but her lungs were documented as clear on that visit. Typos and formatting errors are
28 continued through Patient 1's visits for years.

1 44. Between February 2017, and May of 2015, Patient 1 is documented to have suicidal
2 ideation and require counseling. Respondent did not document any further details or treatment of
3 this medical issue. Respondent lists vertigo and seizure disorder as conditions for Patient 1, but
4 there are no details explaining her symptoms or conditions. Respondent documented two
5 separate visits with Patient 1 on June 30, 2015. At one visit he documents removing moles, and
6 at the other he documents providing a nebulizer treatment and steroid injections.

7 45. Patient 2's records state that in August of 2015, he has respiratory symptoms for 4
8 days. Four days later at a separate visit, he is still noted to be having symptoms for 4 days. Yet
9 in May 18, 2017, Respondent charted that Patient 2 was again having respiratory symptoms for 4
10 days. Again on May 27, 2017, June 16, 2017, June 19, 2017, June 22, 2017, July 3, 2017, July 6,
11 2017, July 22, 2017, July 18, 2017, August 7, 2017, August 15, 2017, and August 21, 2017, he is
12 having respiratory symptoms for 4 days.

13 46. Respondent diagnosed Patient 2 with pneumonia on or about December 31, 2015, but
14 the history and examination and review of systems and vital signs are no different from previous
15 visit notes. Respondent prescribes antibiotics at most of these appointments, but Patient 2's
16 temperature is always documented to be 98.0 degrees.

17 47. At most, if not all of these visits with Patient 2, Respondent documented performing
18 either trigger point injections, or mole removals. There are no details about the procedures, and
19 when interviewed by Board investigators, Patient 2 could not recall whether he had mole
20 removals performed by Respondent. Respondent documented two separate medical appointments
21 with Patient 2 on February 10, 2016, but in one of the visits he documented treating Patient 2 for
22 a respiratory illness with a nebulizer, steroid, and Rocephin, and on the other he documented
23 performing trigger point injections. In January of 2018, Respondent diagnosed Patient 2 with
24 cellulitis, but he documented that the skin examination was normal.

25 48. Similarly, Patient 3 is documented to have pneumonia in June of 2017. But
26 Respondent documented a normal temperature, lung examination heart rate. Between 2016 and
27 2018 Patient 3 received numerous mole removals although her skin was documented as clear.
28 Patient 3 was documented to be crying and upset at almost every visit during the initial years of

1 treatment, and to receive massage therapy of 45 minutes at almost each visit as well. The history
2 of present illness in her notes is virtually the same for every visit between 2012 and 2018.

3 49. Patient 4's medical record also contains numerous inconsistencies. For example, in
4 January of 2016, she is documented to have numerous moles removed, but her skin examination
5 is documented as clear. Six moles were removed on her face and neck in August of 2016, with a
6 normal skin examination documented. Respondent documented prescribing Patient 4 with a five-
7 day course of prednisone between the years of 2014 and 2016. Between February of 2015 and
8 September of 2018, Respondent documented that Patient 4 should be referred to a neurologist to
9 rule out multiple sclerosis. There is no documentation during this time of what symptoms may
10 relate to this medical issue, and there are no notes from a specialist in her records. Throughout
11 2016 and 2018, Respondent frequently documented that he was prescribing Zithromax
12 (azithromycin, a general purpose antibiotic) to Patient 4, but the history and physical are not
13 altered during these treatment times, and her vital signs do not ever show fever or tachycardia.

14 50. Patient 5's medical records also show that she received treatment for respiratory
15 illness when her lungs are noted to be clear. In several visits Respondent notes that he sent
16 Patient 5 to the Emergency Room, but there is no explanation for why or what the outcome was.

17 51. Respondent failed to provide billing records for Patients 1, 2, 3, 4, or 5. He stated
18 that all the billing records for these patients were destroyed in a fire.

19 SIXTH CAUSE FOR DISCIPLINE

20 (False Statement in Records)

21 52. Respondent is subject to disciplinary action under section 2261 and 3527 in that he
22 entered false information into the medical records of Patients 1, 2, 3, 4, and 5. The
23 circumstances are as follows:

24 53. Respondent's medical records for Patients 1, 2, 3, 4, and 5 show that each of the
25 patients had a temperature of exactly 98.0 degrees Fahrenheit at every visit every time they saw
26 Respondent over a five-to-seven-year period.³ These records consist of hundreds of encounters

27 ³ Only one of the five patients ever had any temperature recorded than 98.0 degrees, and
28 this was only on two occasions when she the note is in a different format and is signed
Respondent's supervising physician—not Respondent.

1 comprising multiple appointments for each patient every month. Patients 1, 2, 3, 4, and 5 have
2 the same temperature of 98.0 degrees recorded regardless of whether they are being seen for
3 bacterial diseases or receiving antibiotics. It is not possible that Respondent was unaware of the
4 sameness of each and every temperature recorded for all these several hundred appointments with
5 his patients. Therefore, he knowingly entered, or allowed to be entered a false vital sign for
6 patients in their medical records in violation of BP section 2261.

7 **SEVENTH CAUSE FOR DISCIPLINE**

8 **(Dishonesty)**

9 54. Respondent is subject to disciplinary action under section 3527, 2234, subdivision (e),
10 3502.1, and California Code of Regulations, title 16, section 1399.521. The circumstances are as
11 follows:

12 55. Board investigators subpoenaed Respondent's records for Patient 1, 2, 3, 4, and 5,
13 including billing records for these patients. Respondent provided a response to these subpoenas
14 that excluded billing records for each of these patients. Respondent executed a declaration, under
15 penalty of perjury, stating that the billing records for each of these patients was destroyed by a
16 fire.

17 56. On or about February 12, 2019, Respondent attended an interview with Board
18 investigators who inquired about the fire that destroyed the records at his clinic in Yuba City on
19 Del Norte Avenue. Respondent told the investigators that the fire occurred in January of 2016.
20 He said he believed it was the first or second week of January 2016. He stated that there are two
21 rooms in the back of the clinic, including both a bathroom and file room. He stated that the
22 bathroom fan caught fire and fell down and lit the floor on fire, and that the storage room where
23 the charts and billing records are stored were connected by a fan, the smoke entered the chart
24 room.

25 57. Respondent said that only a small portion of the paper charts were burnt in the chart
26 room, but that the main problem was that the firefighters hosed everything down in the chart
27 room with fire retardant, causing them to be "soaked." As a result of this soaking, the files
28 developed black mold, which required him to shred them.

58. Respondent's account of the fire at his clinic was not accurate. The Yuba City Fire Department has only one report for a call to service at Respondent's clinic. According to the Yuba City Fire Department report, the fire occurred at Respondent's clinic in April of 2014. When firefighters arrived, they observed light smoke in the structure. A firefighter moved toward the back of the building checking rooms as he went. He located a small fire on the floor of the bathroom. He used a water extinguisher to extinguish the fire. Firefighters determined that the source of the fire was a fan that burnt and fell to the ground. The fire on the floor was no more than three inches high and created a burn spot on the flooring. No paper anywhere in the building caught on fire. There was a wastepaper basket containing paper in the bathroom near the burn spot on the floor, but the fire did not reach those papers, and they did not burn. The fire was restricted to the bathroom and did not affect the file room. Firefighters did not spray any water or other material on any documents or papers or any other room than the bathroom. Firefighters reported opening the doors to the adjacent rooms to vent all smoke from them.

59. Respondent committed a dishonest act by falsely reporting to Board investigators the time, nature, and extent of a fire that occurred at his clinic as an excuse for failing to provide the billing records for Patients 1, 2, 3, 4, and 5.

EIGHTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

60. Respondent is subject to disciplinary action under sections 3527, and 2234 in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 13 through 59, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physician Assistant Board issue a decision:

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1 1. Revoking or suspending Physician's and Surgeon's Certificate Number PA 13023,
2 issued to Anthony Martin Kelly, P.A.;

3 2. Ordering Anthony Martin Kelly, P.A., to pay the Physician Assistant Board the
4 reasonable costs of the investigation and enforcement of this case, pursuant to Business and
5 Professions Code section 125.3;

6 3. If placed on probation, ordering Anthony Martin Kelly, P.A. to pay the Board the
7 costs of probation monitoring pursuant to Business and Professions Code section 3527,
8 subdivision (f); and,

9 4. Taking such other and further action as deemed necessary and proper.

10
11 DATED:

March 29, 2019 *Megan R O'Connell for :*

MAUREEN L. FORSYTH
Executive Officer
Physician Assistant Board
Department of Consumer Affairs
State of California
Complainant

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